Corporation for
NATIONAL & COMMUNITY SERVICE

P.O. Box 3430
Carmel, IN 46082-3430
1.866.699.4186

INSTRUCTIONS FOR FILING CLAIM

1. Please fully complete this side of form.
2. Have your doctor complete the back of this form.
3. Mail this form and any other bills to:
   AMERICORPS * VISTA
   Attn: Claims
   P.O. Box 3430
   Carmel, IN 46082-3430
4. Please contact this office if you have any questions.

NOTE: *To expedite the processing of your claim pleasemake sure the diagnosis code, procedure code and providerÕ PIN# are included on the claim and/or receipts.*

TO BE COMPLETED BY PARTICIPANT

ANSWER ALL QUESTIONS THAT APPLY. SIGN WHERE INDICATED BY ☛

PARTICIPANT INFORMATION

Name_____ Date of Birth _____
First Middle Initial Last Month Day Year

Home Address _____
Street City State Zip Code

IMPORTANT Identification Number _____

Are any hospital, surgical or medical benefits or services provided under any group, individual, blanket, school, franchise or no-fault auto insurance plan or under any state, federal or other governmental program (i.e. Medicaid)? • Yes • ••No

If "Yes", give the name and address of the insurance company or other organization providing benefits and the policy numbers.

_____

INSURANCE INFORMATION

Are you covered under Social Security (Medicare) Health Insurance?
• Yes • No
Identification Number:_____

If "Yes," indicate your coverage by checking the appropriate boxes:
- Hospital Only (Part A)
- Medical Only (Part B)
- Hospital and Medical (Part A & B)

Effective Date:_____

Are you covered under any other health insurance?
• Yes • No
Identification Number: _____

Effective Date: _____

Are you covered under medical assistance (Medicaid)?
• Yes • No
Identification Number: _____

Effective Date: _____

Was medical condition related to:

A. Employment • •Yes • No
B. Accident • •Yes • No Date of Accident: _____

Describe illness, injury or symptoms: _____

_____

_____

Date symptoms first appeared: _____

The above information is hereby certified to be true and complete. I agree to reimburse my health plan if this claim for sickness/injury is compensable under Medicare-Medicaid, the Worker's Compensation Act or similar law, if benefits excluded by the provisions of the contract are paid, if such claim is settled or compromised or in the event of recovery from a third party.

Date | Participant's Signature ☛

PERMISSION TO OBTAIN INFO

I permit any physician, pharmacist, hospital or other health care provider, any insurer, prepayment organization or other health plan provider to give my health plan or its representative any medical information about the patient listed above, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate claims for benefits.

This authorization will remain in effect until all matters relating to these claims are concluded. A copy of this authorization will be as valid as the original. I understand that I may receive a copy of this authorization if I ask for one in writing.

Date | Participant's Signature ☛

TOTAL CHARGES submitted with this form: $ Issue Payment to:••• •Participant • Provider